

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>010739</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/13/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>SPRING MILL HEALTH CAMPUS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 W 87TH AVE</b> <b>MERRILLVILLE, IN 46410</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This survey was for the Investigation of Complaints IN00108712 and IN00109225.</p> <p>Complaint IN00108712- Substantiated, no deficiencies related to the allegations are cited.</p> <p>Complaint IN00109225- Substantiated, no deficiencies related to the allegation are cited.</p> <p>Survey dates: June 12 and 13, 2012</p> <p>Facility number: 010739 Provider number: 155764 AIM number: N/A</p> <p>Survey team: Sheila Sizemore, RN - TC Kelly Sizemore, RN Marcia Mital, RN (June 12, 2012)</p> <p>Census bed type: SNF: 32 Residential: 68 Total: 100</p> <p>Census payor: Medicare: 24 Other: 76 Total: 100</p> <p>Residential sample: 4</p> <p>Spring Mill Health Campus was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2. in regard to the Investigation of Complaints IN00108712 and IN00109225.</p>	R 000		

Indiana State Department of Health

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

YVW211

If continuation sheet 1 of 2

Indiana State Department of Health

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R 000	Continued From page 1  Quality review completed on June 14, 2012 by Bev Faulkner, RN	R 000			